

COMMONWEALTH OF KENTUCKY  
OFFICE OF WORKERS' CLAIMS

FILED:

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MEDICAL REPORT OF

DR. \_\_\_\_\_

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**A. PLAINTIFF INFORMATION**

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1. Plaintiff's name: \_\_\_\_\_
2. Address: \_\_\_\_\_
3. Social Security number: \_\_\_\_\_
4. Date of birth: \_\_\_\_\_
5. Plaintiff's job title and employer: \_\_\_\_\_
6. Date of examination(s): \_\_\_\_\_
7. Purpose of examination:
  - ☐ Treatment
  - ☐ Evaluation requested by \_\_\_\_\_
  - ☐ University evaluation
8. Prior examination by this physician (if any) and date:  
\_\_\_\_\_

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**B. PLAINTIFF HISTORY**

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Plaintiff related history of complaints or alleged injury as follows:

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**C. TREATMENT - Prior and Current**

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Based upon a review of records and/or history related by plaintiff, treatment provided for this injury has been as follows:  
(Include any periods of hospitalization.)

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**D. PHYSICAL EXAMINATION**

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Results of physical examination, including objective medical findings to support complaints and/or diagnosis

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**E. DIAGNOSTIC TESTING**

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Check the applicable block for any testing reviewed and relied upon for medical conclusions.

Test	Date	Personally Reviewed	Summary of Results
<input type="radio"/> X-rays		<input type="radio"/> Yes <input type="radio"/> No	
<input type="radio"/> CT Scan		<input type="radio"/> Yes <input type="radio"/> No	
<input type="radio"/> MRI		<input type="radio"/> Yes <input type="radio"/> No	
<input type="radio"/> Myelogram		<input type="radio"/> Yes <input type="radio"/> No	
<input type="radio"/> EMG/NCV		<input type="radio"/> Yes <input type="radio"/> No	
<input type="radio"/> Other (specify)		<input type="radio"/> Yes <input type="radio"/> No	

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**F. SURGICAL PROCEDURE(S)**

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Specify type and date of any surgical procedure. Include operative note if surgery performed by this examining physician.

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**G. DIAGNOSIS**

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**H. CAUSATION**

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Within reasonable medical probability, was plaintiff's injury the cause of his/her complaints? ☐ Yes ☐ No

If the employee sustained more than one injury, which is the cause of his/her complaints?

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**I. EXPLANATION OF CAUSAL RELATIONSHIP**

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Explain how the work-related injury caused the harmful change in the human organism.

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**J. IMPAIRMENT**

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1. Using the most recent AMA Guides to the Evaluation of Permanent Impairment, the plaintiff's permanent whole person impairment is \_\_\_\_\_%.

2. Chapter and Tables utilized to arrive at impairment rating for injuries other than spinal injuries.

Body Part or System	Chapter No.	Table No.	% Impairment of the Whole Person
a.			
b.			
c.			

3. Plaintiff had an active impairment prior to this injury. ☐ Yes ☐ No

A. For affirmative answer, specify condition producing active impairment.

\_\_\_\_\_

B. For affirmative answer, specify percentage of impairment due to the prior active condition.

\_\_\_\_\_

4. Date on which maximum medical improvement was reached: \_\_\_\_\_ 20\_\_\_\_.

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**K. RESTRICTIONS**

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1. The plaintiff described the physical requirements of the type of work performed at the time of injury as follows:
2. Does the plaintiff retain the physical capacity to return to the type of work performed at the time of injury? ☐ Yes ☐ No
3. Which restrictions, if any, should be placed upon plaintiff's work activities as the result of the injury?

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**L. CERTIFICATION and QUALIFICATIONS of PHYSICIAN**

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I hereby certify that the above information is correct and that all opinions were formulated within the realm of reasonable medical probability. A copy of my curriculum vitae is attached if I have not obtained an Office of Workers' Claims Physician Index Number.

Date: \_\_\_\_\_

\_\_\_\_\_  
Full name of Physician

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**Office of Workers' Claims Physician Index Number**

**Instructions for  
Completion of Form 107-I, 107-P, 108-OD, 108-CWP and  
108-HL**

The medical report forms of the Office of Workers' Claims are designed to provide relevant medical information to administrative law judges to assist in determining the occupational implications of a work-related injury or an occupational disease. Therefore, it is important that each section of the forms be carefully and fully completed.

1. All information must be typed or neatly printed.
2. The Office of Workers' Claims maintains a Physician Index with curricula vitae of physicians. Physicians may be included in the index by tendering a copy of a current curriculum vitae with a request for inclusion to: Physicians Index Clerk, **Office of Workers' Claims**, 657 Chamberlin Avenue, Frankfort, Kentucky 40601.
3. Use of the most recent edition of the AMA Guides to the Evaluation of Permanent Impairment is mandated by statute. Reference should be made to page numbers and tables only from the most recent edition for all physical injuries. For psychiatric conditions, the class of impairment should be stated, with reference to impairment ratings provided in prior editions.
4. For Form 108, height of a plaintiff should be measured in centimeters and without shoes. If the plaintiff's height is an odd number of centimeters, the next highest even height in centimeters shall be used.
5. Objective medical findings to support a medical diagnosis means information gained through direct observation and testing of the plaintiffs, applying objective or standardized methods. KRS 342.0011(33).
6. Medical opinions must be founded on reasonable medical probability, not on mere possibility or speculation. Young v. Davidson, Ky., 463 S.W.2d 924 (1971).
7. Pre-existing dormant non-disabling condition is defined as a condition which is capable of arousal into disabling reality by work activities or injury. The condition must be a departure from the normal state of health. KRS 342.020, Newberg v. Armour Food Co., Ky., 834 S.W.2d 172 (1992).

8. Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Revised 1/26/05